THE INDEPENDENT PAYMENT ADVISORY BOARD AS A VEHICLE FOR SAVINGS THROUGH SYSTEM IMPROVEMENT

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SUMMARY OF MAJOR POINTS

Addressing the growth of Medicare spending is a challenging dilemma, on one hand, Medicare is extremely popular and effective, but on the other, Medicare spending growth threatens its continued ability to fulfill its mission.

Medicare spending is driven primarily by excess cost growth throughout the health system—which also is putting pressure on state and local governments, businesses, and households—so treating it only as a Medicare issue can lead to inappropriate policies that will fail to address the problem.

The Independent Payment Advisory Board can serve as a useful tool to address these issues, by focusing attention on broader consideration of policy imperatives.

This will require a broader view of the role of IPAB and collaboration across the executive and legislative branches, but also with state and local governments, providers, patients, and private sector payers and purchasers.

The emphasis should be on:

- Total health care costs, rather than only federal spending.
- Enhancing access and quality.
- Being sensitive to distributional impacts.
- Emphasizing the need to improve performance.
- Establishing coherence and alignment of incentives across the entire health system.

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Thank you, Chairman Pitts, Vice Chairman Burgess, Congressman Pallone, and Members of the Subcommittee, for this invitation to testify on the Independent Payment Advisory Board (IPAB). I am Stuart Guterman, Vice President for Payment and System Reform at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues—particularly payment policy—for a long time, at the Centers for Medicare and Medicaid Services (CMS, and its predecessor, the Health Care Financing Administration) in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC, and its predecessor, the Prospective Payment Assessment Commission) from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen the problems faced by the program persist over time, despite continuous efforts to address and remediate them. I believe that we have an unprecedented opportunity—and an historic imperative—now to address these problems in a comprehensive way, which is the only way they can be solved.

The Congress faces a challenging dilemma in addressing the growth of Medicare spending: on one hand, Medicare is an extremely popular and effective federal program, and some 47 million aged and disabled beneficiaries depend on it for access to the health care they need; on the other, Medicare spending is rising at a rate that threatens the program's continued ability to fulfill its mission, and this growth is putting increasing pressure on the federal budget as well. Achieving an appropriate balance between controlling costs and continuing to achieve the objectives of the program is a difficult task, but one that is of the utmost importance.

An important factor in considering policies to control Medicare and other federal health spending is the fact that it is largely driven by factors that apply across the health system—putting pressure not only on the public sector, including both the federal government and state and local governments, but the private sector as well, including both large and small businesses, their workers and their families, and others who need or may need health care. Treating health care cost growth only as a Medicare issue can lead to inappropriate policies that fail to address the underlying cause of the problem and lead to increasing pressure not only on Medicare and its beneficiaries but on the rest of the health system and the people it serves.[1]

The IPAB, if used appropriately, can serve as a useful tool in attempting to address these issues. Rather than a usurpation of Congressional authority, it should be viewed as an opportunity to focus the attention of policymakers in both the executive and legislative branches (and, in fact, of stakeholders in state and local governments and the private sector, as well) on action that, in the end, has to be taken to avoid an alternative

that everybody should agree will be unpalatable: what will happen if no constructive action is taken and health care costs are allowed to continue to rise as currently projected, with no change the way that health care is financed and delivered and no improvement in health system performance. This will require a broader view of the role of IPAB (and all other available mechanisms), and collaboration among Congress, the Administration, and all parties involved in the health system—a difficult proposition, but one that we have no choice but to attempt. The alternative is not the status quo, but the calamitous situation toward which we are headed if we do not take appropriate action.

In this testimony, I first discuss the growth of Medicare spending in this broader context. I then describe alternative approaches that have been proposed to achieve savings in Medicare spending, and finally consider the role that the IPAB might play in facilitating the implementation of policies that could slow both Medicare and overall spending growth by changing the way we pay for and deliver health care.

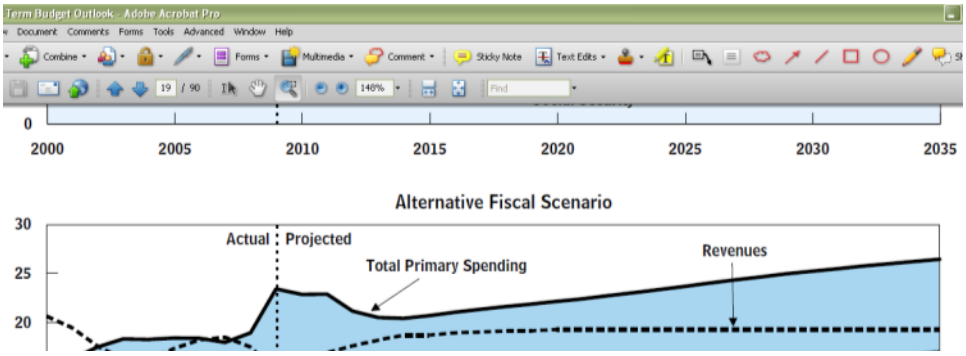
THE FEDERAL BUDGET, MEDICARE SPENDING, AND HEALTH CARE COST GROWTH

The federal budget faces increasing pressure, with a gap between outlays and revenues that is projected to persist or even grow over time (Figure 1). Federal expenditures on health programs play a major role in total federal spending: in 2010, the federal government spent an estimated $820 billion on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)[2] – accounting for 24 percent of all federal non-interest

spending.[3] Moreover, the cost of these programs is projected to increase sharply over time, driving federal spending to unprecedented levels.

Figure 1. Federal Revenues and Primary (Non-Interest) Spending, by Category, Under CBO's Alternative Long-Term Budget Scenario, 2000-2035

Percent of GDP



Source: Congressional Budget Office, *The Long-Term Budget Outlook* (Washington, DC: Congressional Budget Office, June 2010, revised August 2010).

Note: This alternative fiscal scenario adheres closely to current law, following CBO's 10-year baseline budget projections through 2020 and extending the baseline concept through 2035; however, this estimate incorporates a number of assumed exceptions to current law as of the August 2010 revision, including: (1) Medicare physician payment rates continue to grow at the Medicare economic index rather than following the SGR, (2) several policies to restrain spending after 2020 (e.g.., IPAB recommendations) do not go into effect, (3) health insurance premium subsidy cuts scheduled for 2020 do not take effect, and (4) the tax relief policies in effect in 2010 are extended through 2020, after which individual income taxes are adjusted to keep total revenue constant as a share of GDP.

CHIP = Children's Health Insurance Program.

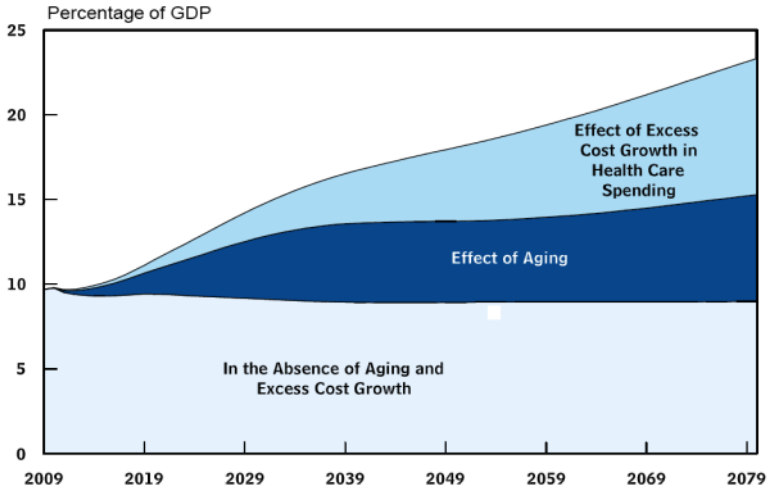
Three things are important to remember, however, in considering policies to reduce the growth of federal spending on health programs. One is that Medicare, Medicaid, and CHIP are not merely line items in the federal budget—they are social programs that provide access to needed health care to vulnerable groups of Americans: the elderly and disabled, families with low incomes, and poor children. Without these programs, many of these people would not be able to get the care they need—subjecting them to increased suffering and imposing costs on society in general in other ways.

Another is that the out-of-pocket cost of health care to Medicare beneficiaries can be substantial: they pay premiums for Part B (Supplementary Medical Insurance, which since 2007 has been indexed to beneficiaries' incomes) and (except for those who qualify

for the low-income subsidy) Part D (Prescription Drug Plan) coverage; in addition, beneficiaries who use most Medicare-covered services must pay deductible and coinsurance amounts; most beneficiaries also contribute to their Part D costs, as well, with the deductible and coinsurance or copayment amounts depending on the plan. These Medicare deductibles and copayments, along with payments for services that are not covered by Medicare, can exact a high cost on beneficiaries—particularly those with low incomes or in poor health. Currently, Medicare covers less than 75 percent of the average beneficiary's total health expenditures, with Medicare beneficiaries with poor health status or low incomes vulnerable to significant financial burdens.[4] Cutting back on Medicare coverage or increasing beneficiaries' responsibilities to pay for their health care costs would exacerbate this situation.

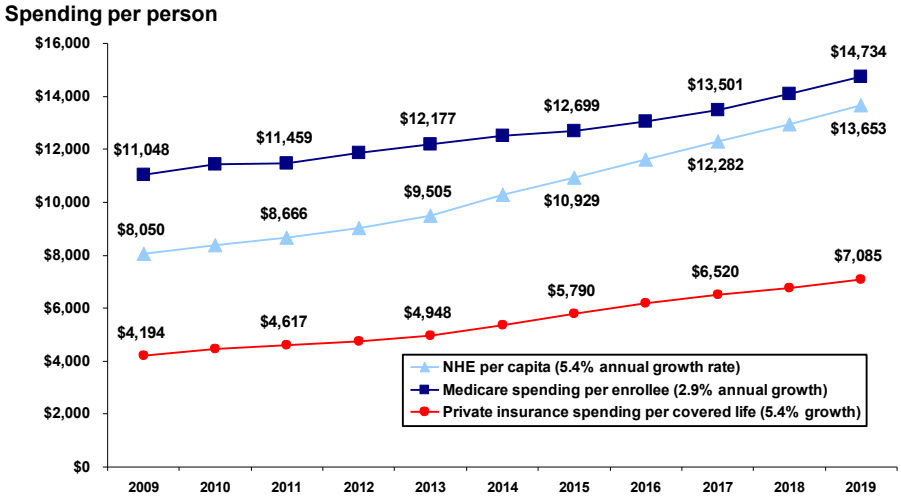
Thirdly, most of the growth in federal health spending is attributable to increasing costs across the health system (Figure 2). Although the aging of the post-war "baby boom" generation into retirement often has been cited as the reason for concern about the solvency of the Medicare program, the Congressional Budget Office estimates that, in the long run, it is excess health care cost growth (cost growth per person that exceeds the growth in per capita gross domestic product) that accounts for most of the increase in federal health care spending—56 percent of the increase in Medicare, Medicaid, and Social Security combined, but 71 percent of the increase in Medicare and Medicaid only (excluding Social Security, since it is affected by aging but not health care costs).[5] In fact, private insurance spending per insured person is projected to increase at a faster pace than federal health spending per person over the next decade (Figure 3).

Figure 2. Sources of Growth in Projected Federal Spending on Medicare, Medicaid and Social Security, 2010 to 2080



NOTE: Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary exceeds the growth rate of per capita GDP.
SOURCE: Presentation by Robert A. Sunshine, CBO Deputy Director, in a presentation on Mandatory Spending to the National Commission on Fiscal Responsibility and Reform, May 12, 2010.

Figure 3. Projected Growth In Medicare and Private Spending per Person, 2009-2019



Source: Commonwealth Fund analysis of data from CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditures Projections 2009-2019, September 2010.

The challenge, then, is not just to reduce the amount that the federal government spends on health care—although reducing health spending growth and the federal budget

deficit that it plays a major part in driving is an important policy imperative. Health care costs are putting pressure not only on the federal budget, but also on:

- State budgets, as Medicaid has become the largest single line item for states, accounting for an average 22 percent of total spending in fiscal 2010 (with wide variation around that average across states);[6]
- Businesses, as large employers' health care costs doubled between 2001 and 2009, while small employers struggle to provide health care coverage at all;[7]
- Workers, whose insurance premiums have more than doubled between 2001 and 2009—more than three times as fast as their earnings;[8] and
- The unemployed, who face the loss of their coverage—60 percent of working age adults who were uninsured at any time during 2010 reported having medical bill problems or accrued medical debt.[9]

The implications of bringing health care costs under control therefore are much broader than the federal budget, and efforts to do so will require concerted efforts across the public and private sectors to elicit changes in the way health care is financed and delivered—not only for Medicare beneficiaries but for all Americans.

APPROACHES FOR ACHIEVING SAVINGS

There are three basic approaches for achieving savings in health spending:

1. Eligibility or benefits—that is, affecting the number of people, the range of services, or the share of spending covered by the programs;

2. Payments—that is, modifying the prices paid for some or all covered services; and
3. Utilization—that is, reducing the number of services provided or changing the mix of services to substitute less intensive for more intensive care.

Various policies in each of these categories have been proposed to slow the growth of Medicare spending, with some very different implications for the participants in public programs and for the providers who serve them. These types of policies also are being developed in the private sector, involving many of the same considerations.

Eligibility or Benefits

In the deliberations on how to address the federal deficit, a number of proposals have been advanced that would reduce Medicare spending by cutting eligibility or benefits. These include proposals to:

- Raise the age of eligibility for Medicare to age 67.
- Income-test eligibility, premiums, or cost-sharing for Medicare beneficiaries.
- Increase Medicare cost-sharing, by instituting increased out-of-pocket requirements and/or prohibiting first-dollar coverage under private supplemental policies.
- Convert Medicare to a high-deductible health plan tied to a health savings account.

- Convert Medicare to a voucher for the purchase of private insurance, with the value of the voucher set below what Medicare would otherwise be projected to spend.

These policies should be examined carefully for their potential effects particularly on the sickest and poorest beneficiaries.

For example, raising the eligibility age to 67 leaves a large number of 65 and 66 year olds with the burden of obtaining other coverage. It has been estimated that, in the pre-reform environment, 200,000 Americans would become uninsured—the Affordable Care Act likely would reduce that number substantially, but the ability to obtain comparable coverage is a concern because of the high premiums that they would face.[10] In any case, out-of-pocket costs would increase for most of the individuals who would be affected.[11] The cost of coverage available through the health insurance exchanges also would increase, because of the addition of older adults into that pool of covered lives, as would costs for employers, with older workers staying in employer-sponsored coverage, and states, with low-income individuals staying in full Medicaid coverage until they are eligible for Medicare. Finally, per beneficiary costs in Medicare would increase, as what currently are the youngest—and healthiest—beneficiaries would not be entering the program until they were older.

Increasing Medicare cost-sharing or converting the program to a high-deductible health plan would shift costs onto the beneficiaries who use the most services. Raising out of pocket costs has been shown to reduce utilization of both unnecessary and necessary care;[12] moreover, 58 percent of total program spending is accounted for by 10

percent of Medicare beneficiaries, who incur an average of $48,000 in Medicare costs; these beneficiaries incur such high costs because they are very sick—not because they are not careful shoppers.[13]

Converting Medicare to a voucher program is a radical approach to slowing Medicare spending, the effects of which are extremely dependent on the level and rate of increase of the voucher that would be given to beneficiaries: the lower the voucher, the more savings could be generated by the proposal—but the more difficult it would be for Medicare beneficiaries to find adequate private coverage without contributing a substantial portion of their own resources. CBO has estimated that the proposal adopted by the House Budget Committee would substantially reduce Medicare program spending and make it more predictable, but beneficiaries would spend considerably more than under the current program, threatening their access to adequate coverage and, consequently, the care they need.[14] By 2022, new enrollees would have to pay at least $6,400 more out-of-pocket to buy coverage comparable to traditional Medicare, and by 2030, the portion of a typical 65-year-old's health care expenses he or she would have to pay out of his or her own resources would increase from 30 percent to 68 percent.[15]

Other policies could be used to deter use of unnecessary or duplicative care and encourage use of lower cost sources of care, structured in a way that would avoid merely shifting costs to beneficiaries by reformulating existing cost-sharing requirements to guide wiser patient choices. Policies along this line could include:

- Targeting Medicare cost-sharing on discretionary care, by reducing or eliminating copayments for essential services while increasing cost-sharing

for services that are supply-sensitive (i.e., elective services the utilization of which is substantially dependent on their level of availability).

- Reducing Medicare cost-sharing on services over which patients have little discretion (e.g., hospitalization), while instituting modest copayments on services such as home health visits (for which there currently is no copayment).
- Value-based benefit design—that is, eliminating or reducing cost sharing for primary care, prescription drugs essential for the control of chronic conditions, and other services that have been shown to be beneficial and highly cost-effective.
- Reference pricing—that is, paying a price that covers the cost of the most cost-effective drug, device, or treatment for each patient's condition, and giving patients the option of obtaining other drugs, devices, or treatments if they are willing to pay the difference in cost out-of-pocket.
- Tiered networks—that is, reducing the cost to the patient for obtaining care from physicians and hospitals that have the same or better outcomes (e.g., lower mortality or fewer complications), but have lower costs over an episode of care.

All of these policies increasingly are being used in the private sector to encourage providers, suppliers, and subscribers to make better choices as to what care is provided and what treatments, drugs, and devices are chosen.

Although the IPAB currently is prohibited from addressing issues of Medicare eligibility or benefits, it could serve as a vehicle for considering how these policies could be developed and implemented not only in Medicare but throughout the health system—pulling together evidence produced by entities like the CMS Innovation Center and the Patient-Centered Outcomes Research Institute (PCORI), and in consultation with MedPAC, the Medicaid and CHIP Payment and Access Commission (MACPAC), organizations of private payers and providers, and patient advocacy organizations, as well as Members of Congress and the Administration.

Payments

A second category of policies that have been proposed to achieve program savings is provider payments. On average—although the relationship between Medicare and private insurers' payment rates varies widely—private insurers typically pay providers more.[16] Providers and private insurers have argued that prices to private insurers are higher to compensate for lower rates from Medicare and Medicaid. Recent evidence, however, suggests that hospitals that face constrained revenues from private insurers operate more efficiently and realize higher margins from Medicare as a result.[17] Under the current mechanism, while Medicare prices are administratively set, prices paid by individual private insurers can vary widely across providers in a given market area and prices paid by different payers to individual providers can vary widely as well (Figure 4).

Figure 4. Wide Variation in Prices within the U.S.: Example of New Hampshire Insurers' Payments for Selected Procedures

	Colonoscopy	Mammogram	MRI (back) (Outpatient)
Insurer A	$1,353 - $4,611	$227 - $881	$645 - $2,790
Insurer B	$1,270 - $3,121	$161 - $564	$640 – $2,292
Insurer C	$1,195 - $3,524	$129 - $612	$732 - $2,659

Source: http://www.nhhealthcost.org/costByProcedure.aspx
Retrieved 14 October, 2010

This wide array of prices for what appear to be similar services—along with precious little information about the price, true production cost, or value of alternative services—makes it difficult for the health care market to send appropriate signals to providers and consumers about how resources should be allocated, what services are valuable, and what providers can best provide them. This may indicate that policies that help the market work better—such as the promotion of greater price transparency and more information about the quality and value of alternative health care strategies, as well as other policies to address the consolidation of market power in the markets for both health care and health coverage—could be required to make sure we obtain maximum value from our health care dollars.

For example, the identification of services for which prices are high relative to what a competitive market price would be can help bring prices in line with efficient

provision of care. One instance of this is brand name drugs and medical devices such as hip replacements, the prices for which in the U.S. are about twice those in other countries. Policies to address this issue might include price negotiation for prescription drugs, medical devices, and durable medical equipment.

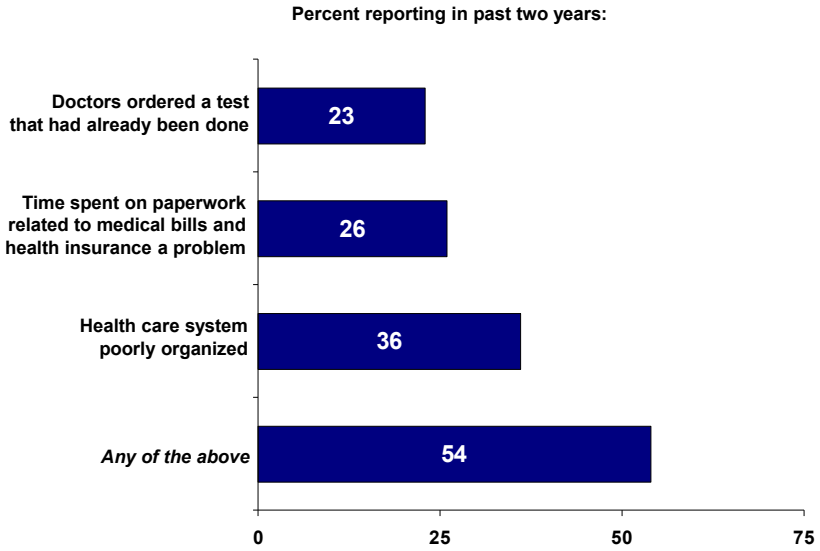
Variation in prices, as well as utilization, also may play an important role in driving variation in spending. Research indicates that a large portion of the difference between spending levels in the U.S. and in other countries can be attributed to price differences[18] and, given the emerging evidence about the wide array of prices for the same services even within the same markets in this country, analysis of the role of prices in driving health spending should be conducted. With the concern about consolidation of market power—even before the advent of the Accountable Care Organization—the development of policies to deal with that trend, and to use it constructively to promote coordinated care, may be an important focus.[19]

The IPAB can play an important role in bringing these considerations together—again, focusing not just on Medicare but as these issues apply more broadly across the entire health system.

Utilization

Proposals to reduce utilization of services is often characterized as rationing and portrayed as denying patients to the right to life-saving care. Yet, the American public indicates in surveys that more than half (54 percent) of all patients experience duplicative tests or poorly organized care (Figure 5).

Figure 5. Potential Waste and Inefficiency: More Than Half of Adults Experience Wasteful and Poorly Organized Care



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2011.

A significant body of research points to significant misuse (i.e., medical errors) and overuse (e.g., duplication of tests or unnecessary care) of services, as well as to underuse of some services (e.g., preventive services, management of chronic conditions, and other forms of primary care that can reduce ambulatory care sensitive hospital and emergency room use), especially by low-income and other vulnerable populations.[20] The Institute of Medicine estimated that as many as 98,000 patients die in hospitals each year as a result of medical errors that could have been prevented.[21] MedPAC estimated that 13.3 percent of hospital readmissions within 30 days of discharge are avoidable.[22] Another study estimated that 30 percent of payments for patients with acute myocardial infarctions and 60 percent of payments for diabetes care were attributable to potentially avoidable complications.[23] Researchers at the Rand Corporation found that patients, on average, receive only 55 percent of recommended care for their health conditions.[24]

Ensuring the right care can not only reduce the cost of care but also improve access, quality, and outcomes.

One way to guide the health system toward more appropriate utilization, as well as invest in services that could reduce hospitalization or hospital readmissions is to give physicians and hospitals incentives to better coordinate care, improve patient outcomes and reduce the resources used in caring for patients. Policies that embrace this strategy include:

- Incentives for primary care practices, community health centers, and health clinics to convert to patient-centered medical homes.
- Shared savings for accountable care organizations.
- Value-based purchasing with rewards for better quality or better patient outcomes.
- Bundled acute and post-acute care global fees.
- Gain-sharing for hospital inpatient physicians which align inpatient physician incentives with hospital incentives.

The Affordable Care Act includes all of these policies, including broad authority for the CMS Innovation Center to pilot test a broad array of payment and delivery system reforms. Continued funding, acceleration, and expansion of this work should be supported.

The IPAB should have the flexibility to quickly adopt and spread successful innovations throughout the Medicare and Medicaid programs and to work with private payers and other stakeholders to encourage broader adoption of initiatives that promise to

reduce cost growth while improving system performance. The challenge is not the absence of creative ideas for achieving savings while improving care, but the distractions of arguments along ideological lines contrasting market-based versus government-based solutions, while in truth a concerted effort by public programs and private payers could reduce administrative costs, leverage change, and yield more rapid transformation of the health care system.

The Independent Payment Advisory Board

In the context of these issues, the IPAB can be a useful tool to effectively address both federal and total health system spending. While the board is currently charged with identifying areas of overpayment in Medicare, its scope of authority could be broadened to include recommendations for Medicaid and private insurer payment policies. The combined leverage of multiple payers could yield price levels and distribution that are closer to what would be offered in competitive markets, as well as greatly reduce administrative burdens on physician practices and hospitals and stimulate delivery system improvement and innovation, such as better care coordination.

Similarly, the IPAB could explore the potential of reference pricing to both lower spending and improve the quality and effectiveness of care that beneficiaries receive. Under reference pricing, new high-priced devices, procedures, and treatment regimens that are not shown to be more effective than existing lower-priced technologies are paid at the same level as those existing equally-effective technologies. Other countries

commonly use this approach not only to save money but also to provide appropriate incentives to innovate in ways that are productive in terms of clinical outcomes. Another set of policies currently within the IPAB's purview is an array of payment approaches designed to encourage providers to become more accountable for the quality and cost of care beneficiaries receive. Promising examples include bundled payment as well as strategies that facilitate closer and more effective management of patients with multiple chronic conditions. In this regard, the IPAB can and should work closely with the new CMS Innovation Center. Previous work that my colleagues and I have published has discussed how these collaborations can be pursued both from the "top down" (that is, with others joining in initiatives developed and implemented by the federal government) and the "bottom up" (with the federal government joining in initiatives developed and implemented by local stakeholders).[25] Collaboration with MedPAC and MACPAC, as well as entities like PCORI, organizations of private payers and providers, and patient advocacy organizations, as well as Members of Congress and the Administration, is critical to the success of this endeavor.

On this score, the IPAB should be considered not as a mechanism for imposing specific policies on the Congress, but instead as a vehicle for focusing attention on a set of issues that are critical, and that everyone agrees are of the utmost importance if we are to preserve not only the solvency of the Medicare program and the federal government, but also the ability of American businesses to continue to compete in increasingly competitive international markets and the access of Medicare beneficiaries and all

Americans to a health system that produces appropriate and effective care when they need it.

To play this role usefully, the scope of the IPAB's authority could be broadened to include working with private sector payers to develop policies that would involve a collaboration of public and private sector initiatives to improve the organization and delivery of health care and slow cost growth. Given that the biggest driver of the projected increase in federal health spending over the coming years is excess health care cost growth—which is a problem that plagues the private sector (businesses and households) as well as the public sector (including both the federal government and state and local governments)—it seems clear that the only way to control federal health spending is to control total health care costs.

Conclusion

The set of policies discussed here is intended to keep the discussion of health care's role in reducing the federal deficit focused where it should be: on pursuing the kinds of improvements in health care organization and delivery that can address the underlying cause of both federal and private health spending growth. By focusing more broadly on the general increase in health care costs, policymakers can alleviate the pressure that health spending has put not only on the federal government, but also state and local governments, businesses, and families.

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